CONSENT FORM

To Our Patients:

I hereby authorize Elite Spine and Sports to provide Chiropractic Services for me. Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. Additional information on side-effects, complications and effectiveness of spinal adjustments is available upon request.

____ (initial here) I understand that if I have any prosthetics or surgical implants (including breast implants, an artificial joint, etc.), I should discuss this with the supervising physician because it may affect care.

____ I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, Elite Spine and Sports reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with reasonable treatment plans.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.

_____ _____

Patient Signature **Date**

Acknowledgement & Understanding

I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Elite Spine and Sports. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections. I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, Medicare, private insurance and all other health plans, to Elite Spine and Sports, 21887 SW Sherwood Blvd. STE A, Sherwood OR 97140

I authorize release of patient's records to third parties requiring these records for determination of financial liability.

By signing this application I affirm under penalty that I have given true complete information.

Dated this _____ day of _____ 20____ .

_____

Patient Signature

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian, I hereby authorize treatment for the following: to any chiropractic treatment deemed advisable , if a parent or legal guardian is not available when the child is brought in for treatment.

_____ DOB _____

Patient's full name

This authorization will be effective as of _____ and expires _____.

Signature_____(parent/guardian) Witnessed by _____

Elite Spine and Sports 21887 SW Sherwood Blvd. Suite A, Sherwood OR 97140 (503)625-0500